Actimmune

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

What is the ICD-10 code? _____

Criteria Questions:

1. What is the diagnosis?

❒ Chronic granulomatous disease (CGD), *Continue to 2*
❒ Severe, malignant osteopetrosis (SMO), *Continue to 3*
❒ Mycosis fungoides (MF) [type of cutaneous T-cell lymphoma], *Continue to 4*
❒ Sezary syndrome (SS) [type of cutaneous T-cell lymphoma], *Continue to 4*

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❒ Other, please specify. _____, *No further questions*

2. Will the requested medication be prescribed by or in consultation with an immunologist or prescriber who specializes in the management of chronic granulomatous disease (CGD)?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

3. Will the requested medication be prescribed by or in consultation with an endocrinologist?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

4. Will the requested medication be prescribed by or in consultation with a hematologist or oncologist?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the request for continuation of therapy with the requested medication?
❒ Yes, *Continue to 6*
❒ No, *Continue to 7*

6. Is the patient experiencing benefit from therapy with the requested medication as evidenced by disease stability or disease improvement?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. What is the diagnosis?
❒ Chronic granulomatous disease (CGD), *Continue to 8*
❒ Severe, malignant osteopetrosis (SMO), *Continue to 9*
❒ Mycosis fungoides (MF) [type of cutaneous T-cell lymphoma], *No further questions*
❒ Sezary syndrome (SS) [type of cutaneous T-cell lymphoma], *No further questions*

8. Will the requested medication be used to reduce the frequency and severity of infections associated with the patient's disease?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. Will the requested medication be used to delay time to disease progression?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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